

066083

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8605425

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Sara Elizabeth Conver					2		15	86	4:05		a.m.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		MONTH 3 DAY 27 YEAR 04		81		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PA		United States				Kent				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown		Kent & Queen Anne's Hospital		POULTRY GROWER		CHICKEN FARM				SELF empl.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Md		Queen Anne's Millington				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rd. 290 Box 101		21651	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
THOMAS		JAMES		MAUDE		SLOEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		166-05-0457		MARGARET MAYERNICK - SISTER - SAME							

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Neuroleptic Oat Cell Ca. of (R) Lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> Approximate interval between onset and death <u>6 mths</u>	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Michael P. Bey MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/16/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL BEY MD		22e. ADDRESS UNICORN MED CTR MILLINGTON MD 21651					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2/17/86		23c. NAME OF CEMETERY OR CREMATORY SILVERBROOK CEM		23d. LOCATION CITY OR TOWN COUNTY STATE WILMINGTON N.C. DEL.	
24. FUNERAL DIRECTOR NAME FELLOWS F.H. BOX 2170 MILLINGTON MD		25a. DATE REC'D. BY REGISTRAR FEB 26 1986		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, except in cases where the death is caused by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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UNION COLLECTION



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8605426

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Elizabeth NMN Day			2a. DATE OF DEATH MONTH DAY YEAR 2 5 86			2b. HOUR 11:38AM				
1. SEX Female		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR AUG 14 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Smoke Run PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.				
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND					13b. COUNTY Q.A.		13c. CITY OR TOWN MILLINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Rt. 1 Box 101 MD RT 290					13f. STREET ADDRESS / ZIP CODE 21657					
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS JAMES			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAUDE SLOEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 166-05-0457		17. INFORMANT ADDRESS SARA CONVER - SISTER - SAME						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Congestive Heart Failure; Complete Heart Block; Previous MI; Aspiration Pneumonia</i>										
19a. DATE OF OPERATION 2/5/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Complete Heart Block			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 2/4 1986 to 2/5 1986, that (I) (we) last saw the deceased alive on 2/5 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE George M. Young			DEGREE MD			22c. DATE SIGNED 2/5/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE M. YOUNG			22e. ADDRESS KENT & QUEEN ANNE'S HOSP.							
23a. BURIAL, CREMATION, REMOVAL CREMATION			23b. DATE 2-6-86		23c. NAME OF CEMETERY OR CREMATORY SILVERBROOK CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE CHESTERTOWN MD			
24. FUNERAL DIRECTOR NAME Fellows F.H. Box 270 MILLINGTON MD			25a. DATE REC'D. BY REGISTRAR FEB 13 1986		25b. REGISTRAR'S SIGNATURE John Davidson					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be attached for use in the burial-transit permit. Then please return certificate, pages 1 and 2, to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above, only injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-1650M 7/B4
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE REGISTRAR		3 - DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 6 0 5 4 2 7	
CERTIFICATE OF DEATH					
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR	
JOSEPHINE CARPENTER ELSTON				February 10, 1986	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR	
Female		white		June 24, 1896	
6a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 AGE (IN YEARS LAST BIRTHDAY)	
Kentucky		USA		89 YRS.	
9a CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9b BALTIMORE CITY OR COUNTY OF DEATH	
Chestertown		Magnolia Hall Nursing Center		Kent Co. Md.	
10 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a CITY OR TOWN		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Kentucky		Nelson Bardstown		Homemaker & music Teacher	
13b STATE		13c CITY OR TOWN		13d STREET ADDRESS / ZIP CODE	
Kentucky		Nelson Bardstown		104 Mockingbird Lane 99999	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Dr. J. G. Carpenter		Lillie Humber		No	
16b SOCIAL SECURITY NO.		17 INFORMANT		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Residuals of Massive Stroke	
407 50 5825		Carolyn E. Noerr Chestertown, Md.			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 12-25, 19 85, to 2-10, 19 86, that (I) (we) lost saw the deceased alive on 2-10, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE DEGREE		22c DATE SIGNED	
		Attending Physician <input type="checkbox"/> Medical Director <input checked="" type="checkbox"/> Staff Physician <input type="checkbox"/>		2-11-86	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
Robert W. Farr		Chestertown, Ms. 21620			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		2/14/86		Bardstown Cemetery	
24 FUNERAL DIRECTOR NAME		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
H. Wells Wells		FFB 13 1986		L. Davidson	

8-15-79

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MINI-TECH

045036

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8605428

1- FOR
STATE REGISTRAR FISHER

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert Bruce Fisher			2a. DATE OF DEATH MONTH DAY YEAR 2/5/86		2b. HOUR 10:34pm						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 6, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.					
7c. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hosp. Inc				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rectifier= whiskey industry			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE S. Kaywood Drive A1801		
14. FATHER'S NAME FIRST MIDDLE LAST John A. Fisher			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Marsh			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. 213 01 2099			17. INFORMANT Kenneth C. Fisher						ADDRESS 21620 Birch Run Road Chestertown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD / Coronary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Michael Bey</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/6/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Bey			22e. ADDRESS Millington, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/10/86		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley			23d. LOCATION CITY OR TOWN COUNTY STATE Timonium Md.			
24. FUNERAL DIRECTOR NAME J. Wells Wells			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR FEB 11 1986			25b. REGISTRAR'S SIGNATURE Julia L. Rosen		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked (a), item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 5 4 2 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles Bradley Kerr		2a. DATE OF DEATH MONTH DAY YEAR February 1, 1986		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 5, 1902	
6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Kent County		MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent Queen Anne Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Kent 13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE General Delivery 21661	
14. FATHER'S NAME FIRST MIDDLE LAST Charles George Kerr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Ann KENN Glenn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-16-9937		17. INFORMANT ADDRESS MD 21661 William C. Kerr P. O. Box 122 Rock Hall	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Colon & liver & lung metastasis</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Intestinal Obstruction</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1/23</i> , 19 <i>86</i> , to <i>2/1</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>1/31</i> , 19 <i>86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Kin Kue Wun</i>		DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kin Kue Wun, M. D.		22e. ADDRESS Kent & Queen Anne's Hospital Chestertown, Maryland 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02-03-86		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery	
23d. LOCATION CITY OR TOWN Kent		STATE MD			
24. FUNERAL DIRECTOR NAME Tom Helfenbein		ADDRESS Rock Hall, MD 21661		25a. DATE REC'D BY REGISTRAR FEB 10 1986	
25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

February 1, 1912

Dear Sir,

Yours

Very

Very

and

Very

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Sarah Catherine Lively			2a. DATE OF DEATH MONTH DAY YEAR 2- 10-86			2b. HOUR 3:00 PM				
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR OCT-11-1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9. CITIZEN OF WHAT COUNTRY? U.S.A		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Kent MD				
12. CITY OR TOWN OF DEATH Chestertown		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR		15. KIND OF BUSINESS OR INDUSTRY VARIOUS		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MD			16b. COUNTY QUEEN ANNE'S		16c. CITY OR TOWN CHURCH		17. 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17. 13e. STREET ADDRESS / ZIP CODE WALNUT STREET 3	
18. FATHER'S NAME (TYPE OR PRINT) William			19. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Jane			20. 18. HENNSLEY				
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			22. SOCIAL SECURITY NO. 215-16-3040		23. INFORMANT ADDRESS MR. William Butler W. M. B. 701 Del.					
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Recurrent Congestive Heart Failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus										
25. DATE OF OPERATION			26. CONDITION FOR WHICH OPERATION WAS PERFORMED			27. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
32. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			33. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			34. LOCATION CITY OR TOWN COUNTY STATE				
35. I certify that (I) (this hospital) attended the deceased from 2/5, 1986 to 2/10, 1986, that (I) (we) lost saw the deceased alive on 2/10, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
36. SIGNATURE H. K. W. L. W. L. N.			37. DEGREE M.D.			38. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		39. DATE SIGNED 2-10-86		
40. PHYSICIAN'S NAME (TYPE OR PRINT) PIN KUE WUN			41. ADDRESS 216 High St. Chestertown, Md. 21620							
42. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			43. DATE 2-15-1986		44. NAME OF CEMETERY OR CREMATORY Male-Female Burial		45. LOCATION CITY OR TOWN COUNTY STATE Chestertown 9A MD			
46. FUNERAL DIRECTOR NAME Chestertown			47. ADDRESS Chestertown MD			48. DATE REC'D. BY REGISTRAR FEB 13 1986		49. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, which will be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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1- FOR
STATE REGISTRAR MASTERSSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 5 4 3 1
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Margery C. Masters</i>			2a DATE OF DEATH MONTH DAY YEAR <i>2 19 86</i>			2b HOUR <i>8:45 AM</i>	
3 SEX <i>F Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>2 24 92</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>93</i> YRS	
7a BIRTHPLACE (COUNTRY) <i>Pennsylvania</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Kent</i> MD	
10 CITY OR TOWN OF DEATH <i>Chestertown</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Magnolia Hall</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i>		13b COUNTY <i>Queen Anne</i>		13c CITY OR TOWN <i>Chestertown</i>		13d STREET ADDRESS / ZIP CODE <i>RFD Queen Anne Co. 21620</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Louis Mountney</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Tobey</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO no</i>		16b SOCIAL SECURITY NO. <i>113-28-6962</i>		17 INFORMANT ADDRESS <i>Madge Crooks 106A Riverview Rd Chestertown, Md.</i>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASCVD -</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>-</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>-</i> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>Pattick A. Molony</i>				22c DATE SIGNED <i>2/19/86</i>		22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Pattick A. Molony</i>	
22e ADDRESS <i>Chestertown, Md.</i>				22f DATE REC'D. BY REGISTRAR <i>FEB 21 1986</i>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>2/24/86</i>		23c NAME OF CEMETERY OR CREMATORY <i>Valley Forge Gardens</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>King Of Prussia. Penna.</i>	
24 FUNERAL DIRECTOR NAME <i>Willis Wells</i>				24b ADDRESS <i>Chestertown, Md.</i>		25a DATE REC'D. BY REGISTRAR <i>FEB 21 1986</i>	
25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodell</i>				25c REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodell</i>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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20% COTTON LIME

WATKINS



1988 11 11

1. DECEASED NAME
(TYPE OR PRINT)

2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
	2	19	86	12:51am

6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
	MONTHS	DAYS	HOURS	MIN.
85 YRS				

9 BALTIMORE CITY OR COUNTY OF DEATH
Kent

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Retired Auto Dealer	

13. STREET ADDRESS / ZIP CODE
106 N. Water St. 21620

ME MIDDLE LAST

Moffett

ADDRESS
Myers 106 N. Water St.
Chestertown, Md.

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Cardiopharmacology history

DUE TO OR AS A CONSEQUENCE OF

(b) MASSIVE ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF

(c) CORONARY ARTERY DISEASE

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

RED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

CITY OR TOWN _____ COUNTY _____ STATE _____

to 2/19, 1986, that (1) (we) lost
death occurred on the date and hour and from the causes stated

MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	27c DATE SIGNED
---	-----------------

599 CRESTERTOWN, MD 21117

23d. LOCATION
CITY OR TOWN COUNTY STATE
Chestertown, Md.

REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE
 FEB 21 1986 *Lelia Davidson-Randall*

MEDICAL CERTIFICATION

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DHMH - 16 60M 7/84
(VRA 15. 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FEB 21 1968

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 5 4 3 3
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William Bryan Newman			2a. DATE OF DEATH MONTH DAY YEAR February 12, 1986			2b. HOUR P M 6:50	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12/15/1915		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Omaha Neb.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	

10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Annes Hospital, Inc		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sewer Cleaner 21620		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Rld Wilkins Lane		13f. CITY OR TOWN Chestertown		13g. STATE Md			

14. FATHER'S NAME FIRST MIDDLE LAST Arthur Newman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Wick	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW 2		16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES) 507 03 5121		17. INFORMANT ADDRESS Cortez, Fla 3045 Mariners Cove Drive	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart G1 bleeding -</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>- Cocaine of stomach</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metabolic Ca</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did not) view the body after death.

23a. SIGNATURE <u>Patrick A. Molony</u>		23b. DEGREE <u>MD</u>		23c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23d. DATE SIGNED 2/13/86	
23e. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony		23f. ADDRESS Chestertown, Md.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/13/86		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Del.	
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24. FUNERAL DIRECTOR NAME <u>William Wells</u>		24b. ADDRESS Chestertown, Md.		25. DATE REC'D. BY REGISTRAR FEB 18 1986		25b. REGISTRAR'S SIGNATURE <u>David R. Riddell</u>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the embalmer's, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 0 5 4 3 4

1. DECEASED NAME (TYPE OR PRINT) WILLIAM JACKSON PINDER			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 6, 1986		2b. HOUR 1 a M
3. SEX MALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 23, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SMYRNA, DEL.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH KENT MD.	
10. CITY OR TOWN OF DEATH CHESTERTOWN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KENT AND QUEEN ANNES HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY FARMING
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MARYLAND KENT COUNTY SUDLERSVILLE			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS BOX 71 CHURCH ST. 21668	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM AARON PINDER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE WILSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-16-8385		17. INFORMANT ADDRESS ANNABELL P. PINDER wife same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) probable myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE MICHAEL BEY MD		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/6/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL BEY MD		22e. ADDRESS UNICORN MEDICAL CENTER, MILLINGTON, D			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/9/86		23c. NAME OF CEMETERY OR CREMATORY SUDLERSVILLE CEM.	
23d. LOCATION CITY OR TOWN COUNTY STATE SUDLERSVILLE, Q.A. MD		24. FUNERAL DIRECTOR NAME ADDRESS FELLOWS F.H. BOX 270 MILLINGTON, MD 21			
24a. DATE REC'D. BY REGISTRAR FEB 13 1986		24b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8605435 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Virginia Lee Porter				2a. DATE OF DEATH MONTH DAY YEAR HOUR 2 17 86 4:30 P.M.			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 15, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Rock Hall		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home Liberty St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse Retired		12b. KIND OF BUSINESS OR INDUSTRY R N.	
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew J. Towers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Audra Judy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS Maynard Porter Liberty St. 21661 Rock Hall, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Ovary DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 9 1/2 yrs DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/26 , 19 83 , to 2/17 , 19 86 , that (I) (we) last saw the deceased alive on 1/25 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Wm H Wood				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WMH Wood				22e. ADDRESS EASTON, MD 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/20/86		23c. NAME OF CEMETERY OR CREMATORY Vet. Cem. Md. Eastern Shore		23d. LOCATION CITY OR TOWN COUNTY STATE Hurlock Md.	
24. FUNERAL DIRECTOR NAME Willie Wells				ADDRESS Chestertown, Md.		25. DATE PREPARED BY MEDICAL EXAMINER FEB 21 1986	

021030

148 21 1960

BP

DHM - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

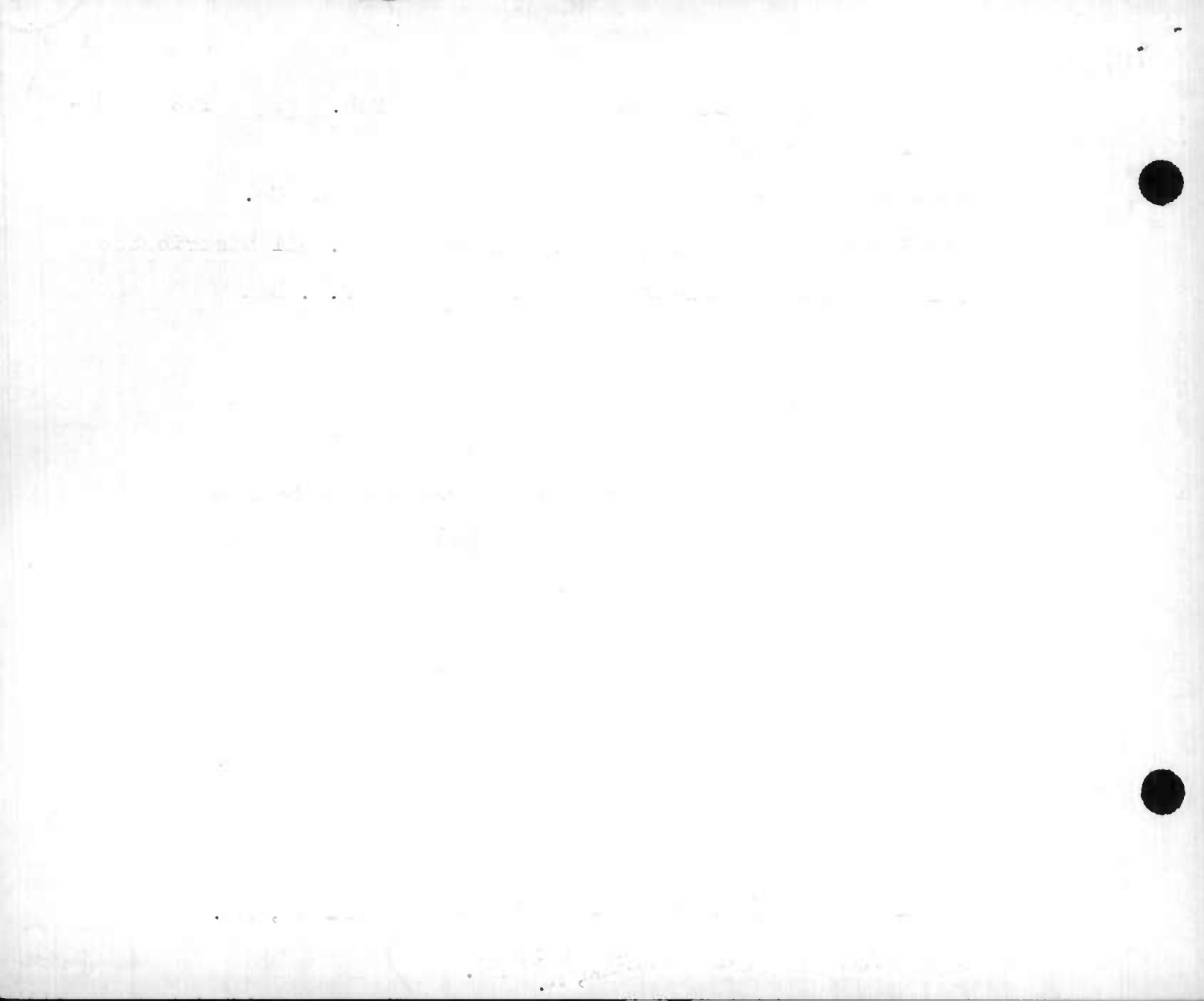
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

065148

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 0 5 4 3 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EVA "BLISS" RYAN			2a. DATE OF DEATH MONTH DAY YEAR Feb. 21 1986			2b. HOUR 11:40 A M			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov. 17 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co. MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Oil Distributor		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Galena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 21635	
14. FATHER'S NAME FIRST MIDDLE LAST Elmer Jarman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Gray					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216 10 9305		17. INFORMANT ADDRESS Deceased while living					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Malnutrition, Non compliance								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Feb 17 , 19 86 , to Feb 21 , 19 86 , that (I) (we) last saw the deceased alive on Feb 21 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Volm C. Arrabala Jr., M.D.				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/25/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Volm C. Arrabala Jr., M.D.				22e. ADDRESS 104 Main Street, Galena, Md 21635					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 2/23/85		23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Galena, Md.			
24. FUNERAL DIRECTOR NAME William Wells				25a. DATE REC'D. BY REGISTRAR MAR 04 1986		25b. REGISTRAR'S SIGNATURE William Randall			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8605437
REG. NO.FOR
1 - STATE
REGISTRAR

056100

DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR				
Garrett			Otto			Schildwachter			February				18,		1986		4:43		A.M.							
1. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS.											
Male			White			April 18, 1908			77			YRS.			MONTHS			DAYS			HOURS			MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH																	
Maryland			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Kent County												MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																	
Chestertown			The Kent and Queen Annes Hospital, Inc			Retired			A.S. Abell Co.																	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE														
Maryland			Kent			Chestertown			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			214 Richard Dr.			21620											
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																							
FIRST			MIDDLE			LAST			FIRST			MIDDLE			LAST											
William			F. O.			Schildwachter			Ethel									Garrett								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS																	
No			213-03-3145			Ruth Schildwachter - Same as #13e																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
			Ventricular Fibrillation												10 minutes											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			(c)			Coronary Artery Disease			5 years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1			Congestive Heart Failure																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																				
			HOUR A.M. MONTH DAY YEAR																							
			P.M.			19																				
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION																				
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET			CITY OR TOWN			COUNTY			STATE											
22a. I certify that (I) (this hospital) attended the deceased from Feb. 11, 1986, to Feb. 18, 1986, the (I) (we) last saw (the deceased) live on Feb. 18, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.																										
22b. SIGNATURE			DEGREE			22c. DATE SIGNED																				
George M Young MD			MD			2/18/86																				
22d. PHYSICIAN'S NAME (OR PRINT)			22e. ADDRESS																							
GEORGE M YOUNG			Kent and Queen Anne's Hosp.																							
			Chestertown, MD																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION																	
Entombment			2-21-86			Dulaney Valley			Cockeysville,			Balto.,			Md.											
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																	
Ruck Towson Funeral Home, Inc.			1050 York Rd.			FEB 21 1986																				
NAME			TOWSON, MD. 21204																							

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
259ABP 36
DHMH - 17
(VR A15 ME (5))1- FOR Film G614 item 18-22a
STATE REGISTRAR 4/8/86 rjaSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 5605438

1. DECEASED NAME (TYPE OR PRINT) Edward Daniel Thompson			2a. DATE KNOWN OF DEATH 2/13/1986		2b. HOUR 9:49 P.M.
3. SEX male	4. RACE white	5. DATE OF BIRTH 8/18/1948	6. AGE (IN YEARS) 37 YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD 2/13/1986
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter Laborer	
13a. STATE Maryland			13b. COUNTY Queen Anne	13c. CITY OR TOWN Sudlersville	
14. FATHER'S NAME James Edward Thompson			15. MOTHER'S MAIDEN NAME Gertrude XXXX Goodyear		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes Viet Nam			16b. SOCIAL SECURITY NO. 216 54 9682		17. INFORMANT Jas. Edw. Thompson
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffusional Intoxication</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 8:50 P.M. 2/13/1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject ingested Drug	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION Woodsedge Apartments Chestertown Kent Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 2/14/86	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/18/86		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem.	
24. FUNERAL DIRECTOR NAME <i>William Wells</i>		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR FEB 20 1986	
25b. REGISTRAR'S SIGNATURE <i>William Wells</i>		25c. REGISTRAR'S SIGNATURE <i>William Wells</i>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

100-30

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8605439

REG. NO.

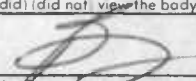
1- FOR
STATE
REGISTRAR

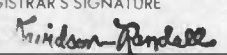
1. DECEASED NAME (TYPE OR PRINT) ESTHER Virginia M. Walters		2a. DATE OF DEATH MONTH DAY YEAR 2 2 86		2b. HOUR 3:30 P.M.
3 SEX FEMALE	4 RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR APR. 1, 1935		6 AGE (IN YEARS LAST BIRTHDAY) 50
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY HOME
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY KENT 13c. CITY OR TOWN MILLINGTON 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE W. CYPRESS ST. 21451				
14 FATHER'S NAME FIRST MIDDLE LAST AUSTIN MELVIN		15 MOTHER'S MAIDEN NAME FIRST MIDDLE EVA SCHWATKA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 221-20-9555		17 INFORMANT ADDRESS ROBT. WALTERS SR. husband same

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension (mild)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs.
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE 	DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/2/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael P. Bey		22e. ADDRESS UNICORN MEDICAL CENTER, MILLINGTON, MD 21651	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 2/5/86	23c. NAME OF CEMETERY OR CREMATORY GALENA CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE GALENA KENT MARYLAND
24 FUNERAL DIRECTOR FELLOWS F.H. BOX 270 MILLINGTON, MD 21651		25a. DATE REC'D. BY REGISTRAR FEB 05 1986	25b. REGISTRAR'S SIGNATURE 

BP _____

TO HOSPITAL, CORPSE-SENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must sign this certificate of death.)



X

BP_____

DHMH - 17

(VR A15 ME (5))

20M 4/B2

STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 05440									
1. DECEASED NAME (TYPE OR PRINT) ELWOOD RICHARD WHEAT									
2a. DATE KNOWN OF DEATH 2/1/86									
3. SEX Male 4. RACE White 5. DATE OF BIRTH 9/9/1906 6. AGE 79 YRS. 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED [X] NEVER MARRIED [] WIDOWED [] DIVORCED [] 9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co.									
10. CITY OR TOWN OF DEATH Worton 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION At home Box # 244 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer retired 12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Md. 13b. COUNTY Kent 13c. CITY OR TOWN Worton 13d. INSIDE CITY LIMITS? YES [] NO [X] 13e. STREET ADDRESS 21678 Box # 244									
14. FATHER'S NAME William Henry Wheat 15. MOTHER'S MAIDEN NAME Mary Elizabeth Bigelow									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16b. SOCIAL SECURITY NO. 200 34 9697 17. INFORMANT Grace Wheat Box # 244 worton, Md. 21678									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure									
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerotic Cardiovascular Disease									
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES [] NO [X]									
21a. EXTERNAL CAUSE WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE [] NOT WHILE [] AT WORK [] AT WORK [] 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes [X], Accident [], Suicide [], Homicide [], Undetermined manner []. Autopsy [], Inspection [X], Inquiry [], and in my opinion									
ACTUAL SIGNATURE Robert W. Farr TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 2-3-86									
EXAMINER'S NAME (TYPE OR PRINT) Robert W. Farr Chestertown Kent Co. Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 2/5/86 23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.									
24. FUNERAL DIRECTOR Willis Wells ADDRESS Chestertown, Md. 25a. DATE REC'D. BY REGISTRAR FEB 06 1986 25b. REGISTRAR'S SIGNATURE John Davidson-Randall									

065147

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 5 4 4 1

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jeanette NMN Williams			2a DATE OF DEATH MONTH DAY YEAR 2 21 86			2b HOUR 11:40A_M	
3 SEX Female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Oct. 28, 1898		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 87 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna/		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10 CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Annes' Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lab. Tech	
12b KIND OF BUSINESS OR INDUSTRY		13a STREET ADDRESS / ZIP CODE RFD Flatland 21620					
14 FATHER'S NAME FIRST MIDDLE LAST John Shepherd				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Shepherd			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 190 16 9571		17 INFORMANT ADDRESS Bruce Williams Canterbury Drive West Columbia Texas			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardiovascular collapse**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Myocardial Infarction**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutesConditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lastPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **hours**

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 9/22/70 , 19 70 , to 2/21 , 19 86 , that (I) (we) last saw the deceased alive on 2/21 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE C. GOTTFRIED BAUMANN M.D. DEGREE				22c DATE SIGNED 2/24/86			
22d PHYSICIAN'S NAME (TYPE OR PRINT) C. GOTTFRIED BAUMANN M.D. ADDRESS MEDICAL BUILDING CHESTERTOWN, MD. 21620				22e ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 2/26/86		23c NAME OF CEMETERY OR CREMATORY Silverbrook Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Wilmington, Del.	
24 FUNERAL DIRECTOR NAME Willis Wells ADDRESS Chestertown, Md.				25 DATE REC'D. BY REGISTRAR MAR 04 1986			
				26 REGISTRAR'S SIGNATURE Davidson-Randall			

003174



ALL AM POWD

LOW COTTON LIGEE

CHERITDOWN, MT. 21230
RECEIVED BY DIVISION
2. 003174 IN HANDS 4/17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 86 05442					
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR				2b. HOUR P. M.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OLIVER R. WRIGHT				Feb. 17, 1986				9 ¹⁵ A.	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Apr. 4, 1891		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 94		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Hall Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Telephone	
13a. STATE Maryland				13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Campus Ave. 21620				14. FATHER'S NAME FIRST MIDDLE LAST Millard Wright		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Oliver			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212 10 0702		17. INFORMANT ADDRESS Durene Larrimore = Chestertown Md.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Complications of old ASCVD</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19____ to 2-17, 1986, that (I) (we) last saw the deceased alive on 2-17, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE A.C. Dick				DEGREE M.D.				22c. DATE SIGNED 2/18/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. Dick				22e. ADDRESS Chestertown, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/21/86		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.			
24. FUNERAL DIRECTOR NAME J. Willis Wells				ADDRESS Chestertown, Md.		25. FILED BY REG. NO. MAR 25 1986			

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